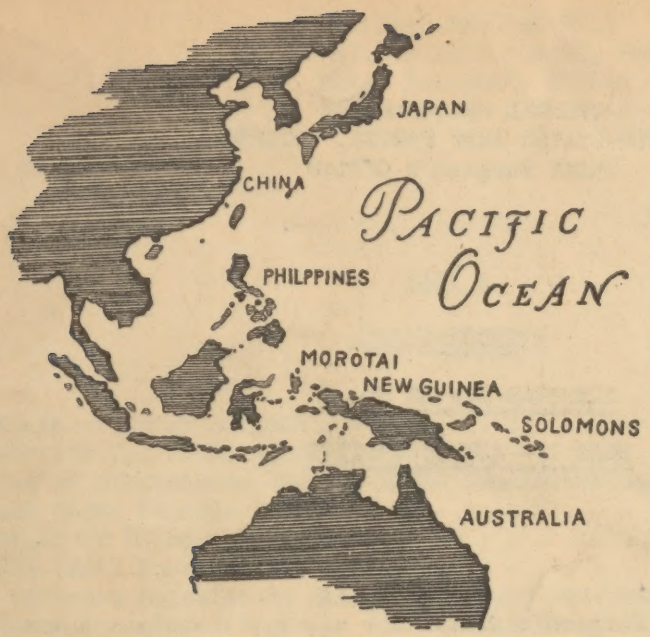

CIRCULAR NUMBER 9

CHIEF SURGEON'S OFFICE

GHQ AFPAC

1 August 1946

GENERAL HEADQUARTERS
UNITED STATES ARMY FORCES, PACIFIC
Chief Surgeon's Office

INDEX

CIRCULAR LETTER NO. 9

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GENERAL HEADQUARTERS
UNITED STATES ARMY FORCES, PACIFIC
Chief Surgeon's Office

APO 500
CIRCULAR LETTER) 1 August 1946
:
NO. . . . . 9)

PART 1

ADMINISTRATIVE

A. GENERAL

I. Organization of Chief Surgeon's Office

1. The following is a list of commissioned personnel currently assigned to the Chief Surgeon's Office:

Brig. General Joseph I. Martin	Chief Surgeon
Colonel Howard F. Currie	Deputy Chief Surgeon

ADMINISTRATIVE DIVISION

Major Frederick H. Gibbs	Executive Officer
Major Hillas B. Brockett	Chief, Miscellaneous Branch
Lt. T. J. Shelton	Chief, Operations Branch

PLANS AND OPERATIONS DIVISION

Colonel John C. Fitzpatrick	Director
Major John V. Painter	Chief, Supply Branch
CWO Harold Hendrix	Chief, Medical Records Branch

PERSONNEL DIVISION

Lt. Colonel Lewis C. Shellenberger	Director
Major Sam A. Plemmons	Assistant Director
Captain Joseph W. Jacobs	Chief, Analysis Branch

MEDICAL INSPECTORS DIVISION

Colonel Albert R. Dreisbach	Director
Lt. Colonel Warner F. Bowers	Surgical

MISCELLANEOUS

Colonel Terry P. Bull	Dental
Colonel Stanley C. Smock	Veterinary
Lt. Colonel Mary G. Phillips	Nursing
Captain Edna Lura	Physical Therapy

II. Case Histories for Publication

2. In order to assist in furnishing material for clinical conferences as part of the proposed teaching program in all military hospitals (Professional Training Program for Medical Officers, Chief Surgeon's Office, 3 July 46), it is contemplated that case histories will be published monthly in this circular for use as a basis for discussion groups. These case histories will contain all pertinent data and laboratory reports, but will be divided into two parts. The first part will contain all elements necessary to arrive at a diagnosis and initiate treatment. This will be accompanied by suggested topics for discussion. In the circular of the following month, the proven diagnosis and a discussion of interesting features of the case will be published. In order to implement this program, it is requested the Commanding Officers of Hospitals have chiefs of professional services in all hospitals in the theater forward such case reports thru technical channels to the Chief Surgeon, AFPAC, as interesting, instructive, or unusual cases near completion. These case histories will be published over the name of the officer or officers submitting the report and since about five cases a month can be published, it is desired that the flow of such case histories begin at the earliest possible date. The histories may contain discussions by doctors actually treating the cases, if desired.

III. Collection of Subsistence Charges USECC Beneficiaries

3. The Surgeon General has called to the attention of this office that bills covering subsistence charges for U. S. Employees' Compensation Commission beneficiaries are being sent directly to the Surgeon General. The subsistence charges are to be collected through the local disbursing officer. A recent indorsement by the Surgeon General is quoted for your information and guidance:

> "1. With reference to basic communication, there are returned herewith bills covering subsistence charges for U. S. Employees' Compensation Commission beneficiaries.

"2. Attention is invited to Circular 175, War Department, 1945, which outlines the procedure for reporting USECC beneficiaries. However, before reporting such beneficiaries it is requested that Forms CA-1, CA-2, CA-16 or CA-17, and CA-20, be prepared and forwarded to the U. S. Employees' Compensation Commission, 285 Madison Avenue, New York 17, New York.

"3. Subsistence charges will be collected through your local disbursing officer, on a WD Form 351, charging the open allotment for USECC beneficiaries during fiscal year 1946 -- 212/60425 (FDGA No.) P 494-07. A true copy of the voucher will accompany report of hospitalization to this office."

IV. Bakers and Cooks Schools

4. The following Bakers and Cooks schools are operated as indicated below:

EIGHTH ARMY

a. Eighth Army Bakers and Cooks School located at Keio University on Route 11 out of Yokohama.

b. 24th Division Bakers and Cooks School located at Osaka, Honshu, Japan.

c. 1st Cavalry Division Bakers and Cooks School located at Camp Drake outside of Asaka, Honshu, Japan.

XXIV CORPS

a. There is no Cooks and Bakers School established in XXIV Corps at present. Maximum use is being made of the quota allotted by the Eighth Army to this command for student attendance at the Eighth Army Cooks, Bakers, and Mess Management School. The present policy is to send future instructors to this school to enable the Divisions and Korea Base Command to conduct similar schools in the future.

b. A Cooks, Bakers, and Mess Management School is to be organized and conducted by Korea Base Command to supplement the students attending the Eighth Army School. Quotas will be allotted to all major commands of this headquarters. This school will have a capacity of 30 students initially, but will be increased to 50 after the first course.

B. SUPPLY

V. Distribution of Technical Films

5. Information received from Army Service Forces, Signal Corps Photographic Center, 35-11 Thirty Fifth Avenue, Long Island City 1, New York, states that initial distribution of the following color subjects is in process:

Misc. 1233 Neurosurgery in Overseas General Hospitals
Misc. 1236 Thoracic Surgery, Part I - Hemothorax With a Consideration of Specific Remedial Exercises
Misc. 1237 Thoracic Surgery, Part II - Foreign Bodies in the Lung and Mediastinum
Misc. 1238 Thoracic Surgery, Part III - Foreign Bodies in the Perciardium and Heart
Misc. 1243 Removal of Magnetic Foreign Bodies from the Eye
Misc. 1244 Removal of Intrathoracic Magnetic Foreign Bodies
Misc. 1245 Repairs of Ruptured Membranous Urethra

One each 16mm print of each of above mentioned subjects is scheduled for shipment from the Signal Corps Photographic Center to the Central Film and Equipment Exchange. Distribution of the above subjects is being made in accordance with specific recommendations from Director, Education and Training Division, Office of the Surgeon General, for showings to interested medical personnel. Further distribution is not contemplated.

C. PERSONNEL

VI. Direct AUS (MAC) Appointments Authorized

6. Authority for appointment of a substantial number of applicants, in the grade of 2nd Lieutenant, AUS, has been established by the War Department. Details for processing applications are set forth in AFPAC Circular No. 57 dated 13 July 1946. Subsequent to the distribution of this circular the War Department eased the requirement whereby applications for Medical Department commissions must be referred to Washington and granted CINC AFPAC radiographic authority to tender direct commissions in the AUS to warrant officer and enlisted candidates who are qualified to assume the duties in the Medical Administrative Corps. The circular announced that appointments are primarily for technical positions. However, qualified applicants for the MAC should be encouraged to apply for a direct commission. It is believed that direct appointments will, in part, alleviate the current situation wherein each major subordinate command is considerably under strength in officers of the MAC.

7. Newly commissioned officers will not be eligible for discharge under readjustment regulations for one year after appointment is tendered.

VII. Surplus Officers Selected on Basis of Longest Overseas Service

8. Medical Department officers who are surplus to work-load requirements or to established ceilings are now required to be selected on the basis of longest current tour of overseas service. Officers of the Regular Army, of all categories, and of Army Specialized Training Program graduates are equally eligible in the selection of surplus. This announcement was made in radio ZX06664, dated 3 July 1946. It is significant that Regular Army, and Categories I, II, and III officers are included since previous considerations were based on retaining such officers to form a dependable nucleus of operating personnel.

9. While adhering to the policy thus established, the War Department recognizes the current shortage of key officer personnel of the Medical Department in this theater and has indicated that numerous exceptions will be authorized

so as to permit retention of key officers who would otherwise be declared surplus--until such time as adequate replacements are obtainable, or until such time as incumbent officers are otherwise eligible for readjustment or for return to the ZI after completing the maximum overseas tour of duty. It is expected that most Regular Army officers will be considered exceptions until they have served the overseas tour outlined in War Department Circular 383, 1945.

10. Officers volunteering for further overseas service are obviously not included in surplus considerations. Every officer who has requested his dependents is considered a volunteer for a period ending one year after arrival of his dependents.

11. In view of the above procedures, it is contemplated that instructions covering Medical Department personnel reports (AFPAC Circular No. 47, dated 7 June 46) will be amended, whereby the roster submitted on War Department AGO Form 8-164 will no longer require a statement of ASRS, RA or ASTP in Column 6 of cited form, but would instead require an indication of officer's status in regard to volunteering for overseas service. Proposed entries would be: a. "VOS - Dep," indicating officer has volunteered for overseas service for a period ending one year after expected arrival of dependents, or b. "VOS - 6-47," meaning that officer volunteered for overseas service for a period ending in June 1947.

VIII. Readjustment Procedures Begin on the Date of Eligibility

12. Occasional instances have been reported to the Chief Surgeon where a unit has permitted Medical Department officers to proceed to the ZI for readjustment 60 days prior to becoming eligible. Such procedure is not in accordance with current instructions. AFPAC Radio ZX 04406, dated 21 June, quotes radiographic instructions received from the War Department which are clear. Medical Department officers will be separated or be aboard transports for return to the United States within 60 days after date of eligibility. It is preferred not to retain any Medical Department officers for any period whatsoever after they become eligible for readjustment.

D. PHYSICAL THERAPY

IX. Physical Therapy Records and Reports

13. It has been observed that records and reports currently in use in Physical Therapy Departments vary greatly in content and method of calculation. In order to standardize such records and reports, the following information is published as a guide:

a. Upon receipt of WD AGO Form 8-83, Record of Physical Therapy, which replaces WD MD Form 55 N, pertinent information as to diagnosis and treatment is copied on WD AGO Form 8-194, Physical Therapy Treatment Record, the card which is kept in the clinic. In the "Month" column of this card enter the month

during which treatment is given, using a separate line for each procedure, e.g.,

June - whirlpool
June - exercise

In the numbered column record treatment given each day, using a check for treatment in the clinic, and a "W" for treatment given on the ward.

b. Cards for patients discharged during the month should be kept in the active file in order to simplify extraction of information for the monthly report. After the report has been prepared, the cards of discharged patients will be removed to an inactive file and kept for three months. Upon the patient's discharge from the hospital, Form 8-83 will be completed and forwarded for inclusion in the clinical record.

c. The Monthly Report of Activities will be prepared as of the last day of each month, and submitted to the Chief of Surgical Service. The data for this report will be obtained and filled in as specified below:

(1) Number of patients receiving treatment on last day of previous month. This figure will be obtained from line 6 of the report for the previous month.

(2) Total number of patients treated during the month. This figure will be obtained by counting the Physical Therapy Treatment Records in the current file, and listed as Hospital patients and out patients.

(3) Number of patients remaining on the last day of previous month plus total number admitted to the hospital during current month. The number of patients remaining on the last day of the previous month will be obtained from the Registrar. The number of patients admitted to the hospital during the current month will be obtained by totaling the number of daily admissions as shown on the Admission and Disposition Sheet for each day of the month.

(4) Per cent of available patients who attended Physical Therapy Department. Obtained by dividing the figure in 2 by the figure in 3.

(5) Total number of treatments given. Obtained by counting the number of treatments (both those checked and those designated by "W") as shown in the numbered columns of the PT Treatment Records for the current month.

(a) Hospital patients - obtained by counting the number of treatments checked.

(b) Out patients - obtained by counting the number of treatments checked.

(c) Ward treatments - obtained by counting the number of treatments designated by "W."

(6) Number of patients receiving treatment of last day of month. This figure will be obtained by counting the cards of patients remaining under treatment after those of discharged patients have been removed - separating active and inactive file.

(7) Procedures employed, and number of each. The various procedures utilized in the clinic during the month will be listed; the number of treatments in each category will be obtained by counting the number of treatments shown opposite each procedure for the current month on the PT Treatment Records.

(8) Personnel assigned to duty on last day of month. Enter the number of commissioned and enlisted personnel. For "Other," enter the number of civilian non-technical and clerical personnel.

(9) The typed name and grade, and signature of the officer-in-charge of the department will appear in the last line of the form.

14. A sample of a Report of Activities follows:

200th General Hospital
APO 242

1 April 1946

SUBJECT: Report of Activities for Month of March 1946

TO : Chief, Surgical Service

The following information on Physical Therapy activities is submitted.

1. Number of patients receiving treatment on last day of previous month 82

2. Total number of patients treated during month 210
   a. Hospital patients 186
   b. Out patients 24

3. Number remaining in hospital on last day of previous month, plus total admitted during current month 563

4. Per cent of available patients who attended PT Department 33

5. Total number of treatments given 3150
   a. Hospital patients 2862
   b. Out patients 288
   c. Ward treatments 95

6. Number of patients receiving treatment on last day of month 91

7. Procedures employed, and number of each
   a. Electrotherapy 177
   b. Thermotherapy 682
   c. Ultra violet 363
   d. Hydrotherapy 708
   e. Massage 320
   f. Therapeutic exercise 900

8. Personnel assigned to duty on last day of month
   a. Commissioned 4
   b. Enlisted 2
   c. Other 1

9. Name and grade John R. Harris, Capt., M.C.

E. VETERINARY

X. Corrections to Consolidated Circular

15. Corrections to Consolidated Circular, Chief Surgeon's Office, 1 June 1946: Change "3 f" in parenthesis, line 4 paragraph 10 g, to read "10 f."

XI. Common Errors in Veterinary Reports

16. Most of the Reports of Veterinary Meat and Dairy Hygiene reaching this office are neat in appearance and indicate careful and accurate preparation. However, many are received in which errors and discrepancies are noted, the most common of which are:

a. Pencil marks, notations, and corrections made with ink over typed figures or letters, are found on all copies. The original of this report is forwarded to the Office of the Surgeon General and it is especially desired that it be neat in appearance.

b. Unauthorized abbreviations and abbreviations that cannot be interpreted are used.

c. Report is not set up according to paragraph 22 a (4), AR 40-2150.

d. Initial and Final reports are not so designated. See paragraph 20, AR 40-2150.

e. Report is not properly forwarded. It should reach this office properly set up in duplicate with all forwarding indorsements also in duplicate. See paragraph 12, Consolidated Circular, Chief Surgeon's Office, 1 June 1946.

f. The entries for the manufacture and issue of ice cream are not properly reported. See paragraph 10 f and g, Consolidated Circular, Chief Surgeon's Office, 1 June 1946.

g. APO not entered.

h. Errors in addition on inserts.

i. Signature not affixed.

XII. Medical Records of American Red Cross Personnel

17. Attention is invited to AR 40-1025, Section XVIII, paragraph 165 b., regarding disposition of medical records of American Red Cross personnel. The individual medical and clinical records (including X-ray films) of members of the American Red Cross will be forwarded direct to the Medical Director, American National Red Cross, Washington, D. C.

XIII. Medical Evacuation of American Red Cross Personnel

18. It has come to the attention of this office that American Red Cross personnel who should be evacuated through military medical channels are not infrequently being allowed to leave the hospital and return to the United States as casuals. When this happens in cases where medical care and/or observation during the trip are advisable, it results in considerable embarrassment to the Medical Department regardless of the fact that the individual has presumably requested permission to return as a casual. It is desired that cases returning to the United States for medical reasons be maintained in medical channels.

PART II

TECHNICAL

XIV. Rapid Qualitative Test for the Sulfonamides (19th Med Gen Lab)

The purpose of this test is to determine whether or not a new patient has taken any of the sulfonamides during the preceding 60 to 70 hours. Recent sulfonamide self medication or previous sulfonamide thereapy can be detected at once. There is practically no time-lag in this test and it will show the physician immediately whether or not further sulfonamide therapy is advisable.

This laboratory tested the Lignin Method and found it to be quite adequate. The method consists of placing a drop of the patient's urine on a piece of wood pulp paper (paper towel, toilet paper, or newspaper; but not filter paper) and adding one drop of five (5%) per cent hydrochloric acid. If a sulfonamide has been taken, a yellow color appears immediately which on standing deepens to an orange color.

The authors of the method state that the color response occurs within one hour after the first ingestion of a sulfonamide and remains positive up to 60 hours after the last dose of drug. The presence of as little as 0.01% of a sulfonamide per cubic centimeter of blood gives a positive response. There is probably nothing in the urine that will give a false positive reaction. The substance probably responsible for the color reaction is lignin, which is the insoluble constituent of wood cells.

Experimental tests carried out by this laboratory were conducted on urine samples from patients at the 4th General Hospital who were on sulfonamide therapy. Normal urines were used as a control.

Consideration should be given to the use of this method of testing for recent sulfonamide therapy on all patients who have been taking an unknown medicine before admission if sulfonamide therapy is to be used.

References:

a. Halloy, L. I. Va. Med. Monthly 69, 334, 1942

b. Bogen, E. U.S. Navy Med. Bull. 41, 1135, 1943

c. Irmish, G. W. J. Urcol. 55, 306, 1946.

XV. Dental Contributions for the Military Surgeon and the Medical Bulletin

Material on dental subjects is urgently desired for publication in the Army Medical Bulletin and the Military Surgeon. Articles on a wide variety of topics can be used, including such subjects as the following:

Organization and operation of the dental service for a theater, army, or smaller unit.

Utilization of dental officers during combat.

Training programs for dental personnel.

First-aid for maxillo-facial injuries.

Unusual problems of the dental service and their solution.

Dental service in foreign armies or peoples.

Evaluations of mobile dental units.

Plans for most efficient utilization of dental officers.

Operative and Prosthetic service for isolated units.

Professional articles on treatment of maxillo-facial, prosthetic, operative, or gingival conditions.

Diet in relation to dental conditions.

Articles are to be forwarded through technical channels to the Surgeon General for publication.

XVI. The Current Problem in Psychiatry and Psychosomatics

Introduction: The conversion from war to occupation has altered many of the problems facing the medical officer and certain problems have been eliminated. For example:

a. Breakdowns due to combat are no longer a problem.

b. The insane seen at the present time are not so violent as those seen during hazardous campaigns.

c. The percentage of patients who are given a psychiatric diagnosis is considerably smaller.

d. The manpower problem, while still present, is no longer critical.

However, certain problems remain:

a. The Army still contains nervous people, and therein resembles every civilian community.

b. Psychoses still occur, just as in every ZI installation or civilian community.

c. In addition, certain administrative problems require psychiatric clearance before the administrative powers feel free to act.

Statement of the Problem: Let us define, then, the main problems confronting psychiatrists in particular, and all medical officers in general, indicating in a broad way their mission:

a. To diagnose, give therapy where indicated, and to make disposition as expeditiously as possible in all medical problems.

b. To give all possible technical assistance to the command to aid in increasing the efficiency of the occupation forces.

c. To make certain that purely administrative problems are handled as administrative problems and are not allowed to get into or remain in medical channels.

Types of Patients Seen: In a general way, there are two large groups of patients referred to the psychiatrist: sick people and those not sick. It is very important that this simple point be quite clear if one is to comprehend the types of disposition recommended. This concept, elementary as it sounds, is poorly understood and medical officers now require rather extensive orientation on this point which during the war was well appreciated. There is a tendency to lump all patients having difficulties not explained on an organic pathological basis into one group called NP's and to take a very definite attitude toward them. The attitudes vary. Some people are over-generous and claim that all these patients are sick, should be gently treated and given every consideration. Another group says they are all just faking to attain desired ends and should be made to serve or receive disciplinary action. Still another brands all this group as "no good" and wants to kick them out of the Army. Such understanding is inadequate. It is not sound from the scientific viewpoint as there is too much emotion and too little logic in these attitudes. This large group of people is heterogeneous and cannot be lumped. The concept of some being sick and others being not sick is emphasized here. First let us consider the sub-groups classified as being psychiatrically sick:

a. Transient Reactions: This refers to the essentially normal person who finds himself in a situation which is most difficult, or to an individual without previous abnormal background who finds himself in an important position unexpectedly and is frightened. This is limited at present to acute situational maladjustments as acute combat exhaustion has disappeared. Full recovery is to be anticipated.

b. Psychoneurotic Disorders: There is no really adequate and concise definition of psychoneurosis. This illness is a chronic disorder characterized primarily by recurring bouts of anxiety, a multiplicity of adaptive defensive reactions, major conversion symptoms, psychosomatic localizations, neurotic depressions, etc. It is a lifelong reaction pattern in which the conflict here occurs within the personality. Symptoms here are contrasted to those occurring

in individuals classed as not sick, where they are produced by conflict between the personality and the environment. It should be called to the attention of all medical officers that psychosomatic reactions are extremely frequent, are often overlooked, and should not be diagnosed by exclusion as is frequently done. Psychogenic reactions may be asthenic, gastrointestinal, rheumatic, cardiovascular, genitourinary, allergic and dermatological, in approximately that order of frequency.

c. Psychotic Disorders: These mainly are schizophrenics and manic depressives. The schizophrenics present several types. The simple type is characterized by loss of interest and flattening of emotions. The paranoid type presents ideational defects with ideas of persecution. The catatonic type shows excitement and stupors and the hebephrenic type shows scattered thinking and silly mood changes. The group is characterized as a whole by a breakdown in certain phases of the thinking processes, resulting in poor logic, vague generalizations instead of specific statements, and too frequent use of symbolism and condensation in thought and speech. The manic-depressive individuals are characterized by their mood swings.

Management of Sick Patients: As would be expected, the management of sick persons will differ radically from those not sick. Let us consider the former. The majority of these are seen at the dispensary and rightly never reach the hospital. If they are seen by a psychiatrist or an understanding medical officer, they receive explanation, reassurance, and medication in the amounts indicated to allow them to continue making a reasonable adjustment in their unit. In certain instances, explanation of the way in which emotions alter physiology will help. Rearrangement in living or working conditions may be indicated. Other phases of good medicine should be used as needed. At times simple reassurance is sufficient. The medical officer in the dispensary should attempt to render as much direct assistance as possible, helping the patient to take a philosophical attitude towards symptoms which will of necessity remain. Patients too sick for care in this echelon need hospitalization where more detailed diagnosis can be made and specialized therapy instituted. In no case should an attitude of censure, sarcasm or disparagement be evidenced by the medical officer. These make the patient apprehensive and frequently aggravate his symptoms. Feelings of guilt or inferiority should not be implanted in the patient because his condition is not at the conscious level. What he needs is information to help him realize the type of problem he is facing. Psychotics obviously should be hospitalized immediately and evacuated promptly.

The group of transient reactions and psychoneurotic disorders must be hospitalized sometimes to receive more definitive diagnosis, evaluation and decision as to disposition. These cases must be handled promptly and efficiently in the hospital. In the first place, promptness saves bed space and therefore is desirable from the administrative standpoint. Secondly, it is medically unwise to have such patients waste time in the hospital. It is proper to make all special studies and give treatment indicated, but redundant examinations, a coddling attitude, and unnecessary hospitalization are definitely bad as they tend to fix the symptoms firmly in the patient's mind, convince him that he is physically ill or that the doctors are probably failing to find a serious disease, and sell him on the benefits of being sick in the hospital. Ordinarily a decision on disposition

is reached in two or three days and not by a long process of exclusion. Disposition will be: (1) duty, (2) therapy and then duty, or (3) evacuation. The majority of patients will be in group two. The ones going direct to duty or evacuation should have the necessary administrative action put in operation as soon as evaluation is completed. Occasionally it may be necessary to change the plan on a given patient, but prompt action with an occasional change of mind is better for the group as a whole than a dilatory policy based on fear of making a mistake.

Management of Individuals not Sick: Now let us consider the people referred to the psychiatrist or hospitalized and whom we class as not sick. These men do not constitute a medical problem and they present nothing new which is a medical condition. Rather, they have personality defects or immature reactions from which they never have grown up. According to Army Regulations these are administrative problems and should be kept out of medical channels. The group is comprised of paranoid personalities, anti-social personalities, homosexuals, over-aggressive individuals, enuretics, and soldiers unable to learn enough to carry on their duties. Some are on the defensive all the time, blaming others for their troubles, some cannot get along with other people, some are ordinary alcoholics who drink to obscure their deviations from themselves, some react with excessive emotion to mild disappointments or annoyances, some allow over-aggression to get them into difficulties. Others are merely inadequate and inapt. Many of them complain of minor and inconsequential somatic or psychological symptoms. All are referred to the psychiatrist so that the possibility of a medical condition can be ruled out. This is wise because it is possible for a medically sick patient to act in a peculiar way and show unsocial tendencies. The psychiatrist therefore sees the soldier to eliminate the possibility of a medical patient being given disciplinary action for behavior beyond his power to control. The disposition in these cases always is duty. Many are troublemakers in the hospital, rebelling at hospital routine, and not only are not helped by hospitalization but seriously interfere with the therapy of other patients. They fight, argue, and get drunk. They do not want help. They just want their own way. Their organization may keep them, may take disciplinary action, or may arrange for discharge from the service under the appropriate provisions of AR 615-368 (Undesirable Habits and Traits of Character), or AR 615-369 (Inaptness). These soldiers should not be allowed to get into medical channels of evacuation as they are administrative problems. They are frequently returned to the hospital time after time by their units, but correct medical disposition continues to be duty regardless of the number of unnecessary hospitalizations. They are not entitled to a medical discharge and pension at the taxpayers' expense.

Functions of Psychiatrists: At the Division level, psychiatrists can perform an extremely valuable function. They conserve man power and prevent unnecessary hospitalization by evaluating soldiers who are nervous and by giving indicated therapy. They make recommendations about the soldier's job, may arrange more compatible surroundings, or may refer soldiers to proper agencies about personal problems. They recommend hospitalization of soldiers with nervous sickness requiring hospital care and/or disposition. When the command desires, they make individual recommendations on soldiers being considered for administrative action such as court-martial, discharge, etc. They also are available

for special training such as studies in morale and methods of improving it, and studies in repeaters among venereal disease cases. At the hospital level, the psychiatrist is concerned with patients admitted to his wards and with consultations. An additional vital function, frequently under-emphasized, concerns his duty in assisting to orient all other medical officers in the recognition and management of psychosomatic manifestations. He should emphasize the extreme frequency of these conditions, demonstrate how definitive diagnosis and evaluation can be made early and be sure that they understand the general principles of psychiatric treatment.

PART III

STATISTICAL

XVII. Evacuation

During the month of June the following patients were evacuated from the several major commands:

	AIR	WATER	TOTAL
EIGHTH ARMY	271	565	836
AFMIDPAC	73	38	111
AFWESPAC	64	698	762
XXIV CORPS	(Unclassified)		

The following are the evacuations per 1000 strength for the month of June:

JAPAN	5.31
KOREA	2.54
AFMIDPAC	3.03
AFWESPAC	6.68
AFPAC	5.02

As of 30 June 1946 the following number of patients were awaiting evacuation:

EIGHTH ARMY	54
AFMIDPAC	42
AFWESPAC	95
XXIV CORPS	41
TOTAL	232

XVIII. Hospitalization

The Bed Status Report of 30 June is as follows:

	TOTAL T/O BEDS PRESENT	TOTAL T/O BEDS ESTABLISHED	TOTAL T/O BED OCCUPIED
EIGHTH ARMY	6,500	5,619	3,213
AFMIDPAC	2,425	2,425	989
AFWESPAC	6,225	4,738	2,973
XXIV CORPS	2,350	2,250	885
TOTAL	17,500	15,032	8,060

Number of authorized beds, percent of authorized beds occupied percent of operating beds occupied and percent of actual military strength in hospitals as patients are listed below:

	BEDS AUTHORIZED	% AUTHORIZED BEDS OCCUPIED	% OPERATING BEDS OCCUPIED	TOTAL PATIENTS IN HOSPITAL % OF ACTUAL MILITARY STRENGTH
JAPAN	5,556	58	57	2.04
KOREA	2,403	37	39	1.71
AFMIDPAC	1,891	52	41	2.69
AFWESPAC	5,498	54	63	2.58
AFPAC	15,244	53	53	2.33

Actual strength equals 95% of authorized strength.

Tables showing various admission rates are listed below:

ADMISSION RATES PER 1000 PER ANNUM

All Causes

Week Ending	AFPAC	AFMIDPAC	AFWESPAC	JAPAN	KOREA
3 May 46	695	316	704	796	614
10 May 46	735	357	829	787	646
17 May 46	756	342	731	773	534
24 May 46	648	153	666	777	534
31 May 46	603	309	584	694	514
7 Jun 46		176	*	731	601
14 Jun 46		176	*	*	*
21 Jun 46		125	*	*	*
28 Jun 46		115	*	*	*

Mycotic Dermatoses

3 May 46	9	1.4	12	12	1
10 May 46	8	1.4	9	11	2
17 May 46	9	3.1	12	12	2
24 May 46	6	1.5	7	9	0
31 May 46	10	4.3	3	19	.9
7 Jun 46		5	*	13	1.8
14 Jun 46		0	*	*	*
21 Jun 46		5.6	*	*	*
28 Jun 46		8.5	*	*	*

ADMISSION RATES PER 1000 PER ANNUM

Venereal Disease

Week Ending	AFPAC	AFMIDPAC	AFWESPAC	JAPAN	KOREA
3 May 46	151	15	142	222	33
10 May 46	156	19	180	208	45
17 May 46	170	13	153	219	60
24 May 46	133	0	143	189	34
31 May 46	138	10	144	189	47
7 Jun 46		5	*	222	65
14 Jun 46		22	*	*	*
21 Jun 46		8	*	*	*
28 Jun 46		14	*	*	*

Malaria

3 May 46	38	7.1	51	40	24
10 May 46	38	5.6	45	41	34
17 May 46	28	0	34	29	29
24 May 46	27	1.5	39	27	21
31 May 46	27	0	30	33	22
7 Jun 46		11.6	*	32	31
14 Jun 46		4.2	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		12.7	*	*	*

Amebic Dysentery

3 May 46	3.2	0	6.7	2.1	2.8
10 May 46	3.7	1.4	7.6	1.9	3
17 May 46	5	0	17.3	.9	0
24 May 46	5	0	15	.9	2.8
31 May 46	2.3	0	7	0	0
7 Jun 46		0	*	1.3	.9
14 Jun 46		0	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		0	*	*	*

Bacillary Dysentery

3 May 46	.1	0	0	.3	0
10 May 46	.3	0	.4	0	.9
17 May 46	.1	0	.4	0	0
24 May 46	0	0	0	0	0
31 May 46	.4	0	1.3	0	0
7 Jun 46		0	*	0	0
14 Jun 46		2.8	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		1.4	*	*	*

ADMISSION RATES PER 1000 PER ANNUM

Common Diarrhea

Week Ending	AFPAC	AFMIDPAC	AFWESPAC	JAPAN	KOREA
3 May 46	5	4.2	7.7	7.1	1
10 May 46	7	2.8	11.8	7.6	.9
17 May 46	5	3.1	12.2	3.6	.9
24 May 46	7	4.5	14.6	3.8	2.8
31 May 46	4.5	6	10.1	1.3	.9
7 Jun 46		3.3	*	2	3.7
14 Jun 46		0	*	*	*
21 Jun 46		1.4	*	*	*
28 Jun 46		0	*	*	*

Pneumonia, Primary, Atypical

3 May 46	7	0	11	6.1	6
10 May 46	4	2.8	9	2.8	3
17 May 46	6	1.5	14	3.2	5
24 May 46	5	0	11	2.2	.9
31 May 46	6.8	4.5	13	3.9	2.8
7 Jun 46		5	*	3	8.4
14 Jun 46		1.4	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		0	*	*	*

Influenza

3 May 46	.8	0	.4	.9	1.9
10 May 46	1.3	2.8	.9	2.2	0
17 May 46	1.8	0	2.8	1.9	.9
24 May 46	3.4	0	8.6	1.6	0
31 May 46	2	1.5	4.4	.9	0
7 Jun 46		0	*	1.3	0
14 Jun 46		0	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		0	*	*	*

Common Respiratory Diseases

3 May 46	83	20	56	122	58
10 May 46	67	26	39	101	52
17 May 46	66	40	36	102	42
24 May 46	53	6	37	92	63
31 May 46	67	36	44	97	41
7 Jun 46		15	*	117	41
14 Jun 46		37	*	*	*
21 Jun 46		32	*	*	*
28 Jun 46		24	*	*	*

ADMISSION RATES PER 1000 PER ANNUM

Injury

Week Ending	AFPAC	AFMIDPAC	AFWESPAC	JAPAN	KOREA
3 May 46	67	49	57	76	72
10 May 46	72	74	68	75	66
17 May 46	71	68	72	81	45
24 May 46	61	20	56	71	69
31 May 46	66	66	55	74	60
7 Jun 46		25	*	67	61
14 Jun 46		14	*	*	*
21 Jun 46		14	*	*	*
28 Jun 46		21	*	*	*

Disease

3 May 46	627	266	647	720	542
10 May 46	664	283	761	711	579
17 May 46	611	274	659	691	489
24 May 46	586	134	611	706	464
31 May 46	537	243	528	620	455
7 Jun 46		151	*	664	539
14 Jun 46		161	*	*	*
21 Jun 46		111	*	*	*
28 Jun 46		03	*	*	*

Infectious Hepatitis

3 May 46	6	0	6	9.5	2.8
10 May 46	5	1.4	4	6.9	3
17 May 46	5	0	6	7.1	.9
24 May 46	6	0	5	5.8	6.5
31 May 46	5.8	0	5	9	1.9
7 Jun 46		0	*	3	1.8
14 Jun 46		0	*	*	*
21 Jun 46		0	*	*	*
28 Jun 46		0	*	*	*

* Report not yet received.

Articles for Publication in Circular

It is desired that the Monthly Circular Letter published by the Chief Surgeon, GHQ, AFPAC, be of maximum value to all of the Medical Department personnel in the field. To that end, articles of professional or administrative nature that might be of general interest are needed. All Medical Department officers as well as the Commanding Officers of Medical Department units and the Surgeons of the major commands are solicited for articles of administrative or technical value. Such articles should be forwarded so as to reach the Chief Surgeon, AFPAC, not later than the 20th of the month preceding the publication of the circular in which it is to appear.